

MDR Tracking Number: M5-04-3193-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on May 24, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visit (99213), electrical stimulation (97014), therapeutic activities (97530), hot/cold therapy (97010), massage therapy (97124), and ultrasound (97035) **were not** medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

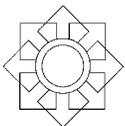
Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatment listed above were not found to be medically necessary, reimbursement for dates of service from 09-05-03 to 09-25-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 7th day of September 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

Enclosure: IRO decision



Texas Medical Foundation

Barton Oaks Plaza Two, Suite 200 • 901 Mopac Expressway South •
Austin, Texas 78746-5799
phone 512-329-6610 • fax 512-327-7159 • www.tmf.org

NOTICE OF INDEPENDENT REVIEW DECISION

August 19, 2004

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker: _____
MDR Tracking #: M5-04-3193-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a TMF physician reviewer who is board certified in anesthesiology which is the same specialty as the treating physician, provides health care to injured workers, and licensed by the Texas State Board of Medical Examiners in 1989. The TMF physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This male patient evidently injured himself at work on _____. There is no documentation provided to indicate how he injured himself, however, he has been receiving physical therapy and has had two (2) lumbar facet joint nerves rhizotomies on 07/08/03 and 07/15/03.

Requested Service(s)

Office visit (99213), electrical stimulation (97014), therapeutic activities (97530), hot/cold therapy (97010), massage therapy (97124), and ultrasound (97035) from 09/05/03 through 09/25/03

Decision

It is determined that the office visit (99213), electrical stimulation (97014), therapeutic activities (97530), hot/cold therapy (97010), massage therapy (97124), and ultrasound (97035) from 09/05/03 through 09/25/03 were not medically necessary to treat this patient's medical condition.

Rationale/Basis for Decision

Medical record documentation does not indicate the necessity for the above named services. Radiofrequency thermocoagulation of lumbar facets alone is not an indication for physical therapy. In addition, radiofrequency thermocoagulation often affords enough relief that physical therapy is not medically necessary.

Therefore, the office visit (99213), electrical stimulation (97014), therapeutic activities (97530), hot/cold therapy (97010), massage therapy (97124), and ultrasound (97035) from 09/05/03 through 09/25/03 were not medically necessary to treat this patient's medical condition.

Sincerely,



Gordon B. Strom, Jr., MD
Director of Medical Assessment

GBS:vn

Attachment

Information Submitted to TMF for TWCC Review

Patient Name: ____

TWCC ID #: M5-04-3193-01

Information Submitted by Requestor:

- Pampa Physical Therapy letter dated 07/14/04, exercise flow sheet 09/03, SOAP notes 09/03
- Acute and Chronic Pain and Spine Center Rx's for PT x2, letter to Texas Mutual Ins. Co. 07/15/04
- Operative Procedure Note 07/08/03 and 07/15/03

Information Submitted by Respondent:

- Highpoint Pharmacy fax dated 07/15/04, letter of withdrawal
- TWCC forms
- Table of disputed services
- Texas Mutual Ins. Co. EOB's